BEFORE THE

STATE OF CALIFORNIA

OCCUPATIONAL SAFETY AND HEALTH

APPEALS BOARD

In the Matter of the Appeal of: PURITAN ICE COMPANY 4585 West Main Street Guadalupe, CA 93434 Employer	Docket No. 01-R4D5-3893 **DECISION AFTER RECONSIDERATION**

The Occupational Safety and Health Appeals Board (Board), acting pursuant to authority vested in it by the California Labor Code and having taken the petition for reconsideration filed in the above entitled matter by the Division of Occupational Safety and Health (Division) under submission, makes the following decision after reconsideration.

JURISDICTION

On August 15, 2001, a representative of the Division conducted an accident investigation at a place of employment maintained by Puritan Ice Company (Employer) at 4585 West Main Street, Guadalupe, California (the site). On September 7, 2001, the Division issued a citation to Employer alleging a serious, accident-related violation of section[1] 4556 [railing for ice breaker/crusher] with a proposed civil penalty of $12,600.

Employer filed a timely appeal contesting the existence and classification of the alleged violation and the reasonableness of both the abatement requirements and the proposed civil penalty, and asserted the affirmative defense of an independent employee act. On November 14, 2002, a hearing was held before Barbara J. Ferguson, Administrative Law Judge (ALJ), in Ventura, California. Thomas Feher, of LeBeau Thelen, LLP, represented Employer. Albert Cardenas, Staff Counsel, represented the Division. On January 22, 2003, the ALJ issued a decision granting Employer's appeal and setting aside the proposed civil penalty.

[1] Unless otherwise specified, all references are to sections of Title 8, California Code of Regulations.

On February 18, 2003, the Division filed a petition for reconsideration. On March 19, 2003, Employer filed an answer to the petition. On April 8, 2003, the Board took Employer's petition under submission and stayed the ALJ's decision pending a decision after reconsideration.

EVIDENCE

Employee Santos De Leon, Jr. (De Leon) suffered a crushing injury to his left foot on August 13, 2001, while attempting to unjam an ice block caught in an ice-crushing machine.

Employer's co-owner and president, Renaldo Pili (Pili), characterized the ice-crushing machine as a portable, hopper/drum combination. The drum is directly beneath the top of the hopper. Above the hopper, steel walls enclose three sides of the hopper entrance. On the remaining side there is an opening to push through blocks of ice. Trucks loaded with ice blocks weighing approximately 300 pounds each are backed up to the ice-crushing machine and a hinged chute connects the truck to the ice-crushing machine. There are no rails or guards in front of the opening or along the sides of the chute. The ice blocks have a typical dimension of 11" wide x 22"long x 44 inches high (and sometimes are over four feet but less than five feet in height). The blocks are stacked in the truck vertically and remain in the vertical position as they are pushed into the drum. Pili stated that employees are instructed to inspect the crusher drum before use to make sure there is no debris, to wet the surface of the ramp, then start the crusher and move 2 or 3 ice blocks at a time through the crusher. Employees are told not to go onto the chute when loading the ice into the drum. Pili conceded that the ice will jam on occasion. Employees are instructed that when a jam occurs, they are to shut off the machine and use a shaver, similar to a fork, to break the ice into pieces.

Employer's safety consultant James Hodge (Hodge) examined the truck and chute after the accident and took several photographs of the machine. He testified that the height of the bed of the truck measured approximately 52 inches. Hodge believed the chute to be level with the bed of the truck at the time of the accident.

De Leon had used this portable ice-crushing machine 10 or 15 times prior to his accident. He testified that he was never trained to turn off the machine if there was a jam. When a jam occurred he would use tongs to lift up the end of the ice and turn it in place. He had observed other employees using tongs in this same manner to unjam the ice. De Leon stated that Pili had witnessed him using tongs before to unjam the ice without comment. He stated that jams occurred more frequently on this particular machine because the drum was crooked. De Leon testified that one could not step directly from the bed of the truck to where the drum with the spikes was located because the

steel chute (ramp)[2] connecting the two areas was approximately five feet in length. The ramp was approximately four feet from the ground. He based the height of the ramp on the fact that he is five feet, five inches tall, and when he stands on the ground the chute is level with his shoulder. De Leon added that the ice drops three to four inches when it falls from the end of the ramp into the drum.

Immediately prior to his injury De Leon stated that he had thrown a cracked block of ice into the drum. Because of the crack, the ice broke into two pieces upon contact with the spikes. De Leon then got a second block of ice and tried two or three times to unjam the first piece of ice. When this did not work he pulled the second block of ice out and placed it back in the truck bed. As he returned to the entrance of the machine, he slipped on melted ice on the chute and fell towards the drum. His left foot went into the spikes. The tongs he was holding at the time fell into the drum causing the spike rotation to stop. He then reached up and turned off the machine. De Leon spent 21 days in the hospital as a result of injuries to his ankle and foot.

De Leon stated that Pili had previously reprimanded him before for using his foot to unjam the ice but he could not recall how long before his accident the reprimand occurred. However, De Leon denied using his foot to clear the ice jam at the time of his accident.

Division Safety Compliance Office Dwight Goossen (Goossen) commenced his investigation of the accident on August 15, 2001. At that time he spoke with Pili who explained to him how the accident occurred. As part of his investigation Goossen examined and took photographs of the ice-crushing machine, the chute, and the truck, all which had been moved since the accident and set up for purposes of inspection. Pili informed Goossen that each block of ice weighs approximately 300 pounds. Once the ice is crushed by the spikes in the drum, the ice drops down and is blown to a location for processing. The spiked drum was situated approximately six inches below the end of the chute where it met the entrance to the drum. Goossen also measured the distance between the ground and the chute and said it was approximately four feet.

Although Goossen did not observe the operation of the ice-crushing machine involved in the accident, he has observed other similar machines in operation. He explained that a typical hopper has four sides and acts as a funnel for the material being pushed through. It was Goossen's opinion that the rotating drum with a hopper below performed a similar action as other hoppers he had observed. Based on his experience Goossen stated that these types of machines run until they are manually turned off. He also stated that

[2] The witnesses used the terms "chute" and "ramp" interchangeably.

the spiked drum rotates very fast during the crushing action. Goossen stated that the steel ramp was the working level referenced in section 4556 because the employee worked at that level. Since the top of the hopper was less than 42 inches above the working level, Goossen stated there should have been railings along the ramp to prevent an employee from slipping. Goossen conceded that railings along the ramp would not have prevented the accident.

Based on his investigation Goossen issued a citation to Employer for a serious, accident-related violation of section 4556.

ISSUES

1. Did the Division establish a violation of section 4556?
2. Was the violation of section 4556 serious?
3. Was the violation accident related?

FINDINGS AND REASONS FOR DECISION AFTER RECONSIDERATION

1. Section 4556 Is Applicable To the Violative Condition.

In vacating the citation alleging a violation of section 4556 and setting aside the proposed penalty, the ALJ determined that the Division did not establish the applicability of section 4556[3] and found that it would have been more appropriate to cite employer for violation of section 3314(a).[4]

The Division states in its petition that although the Employer could have been cited for violating section 3314(a), the facts nonetheless established a violation of cited section 4556. According to the Division, "coincident" violations of two safety orders that are equally applicable, as in this case, are distinguishable from Board precedent establishing that the Division's failure to cite the more appropriate safety order could serve to nullify a citation based upon a non-applicable safety order. The Board agrees.

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[3] The Division has the burden to show by a preponderance of the evidence the applicability of the safety order cited and the violation. (See *Howard J. White, Inc.*, Cal-OSHA App. 78-741, Decision After Reconsideration (June 16, 1983).)

[4] In this case, the ALJ found that the Division failed to establish that section 4556 was the applicable safety order that should have been cited based on the means and methods used by Employer in its ice crushing process. (ALJ Decision, p. 5). Since the lock-out tag-out provisions of section 3314 applied to the "unjamming" activity De Leon was performing at the time of his injury, the ALJ concluded that the failure to de-energize the ice crushing machine before attempting to clear the jam, was the actual violative condition, and thus, section 3314(a) applied to the violative condition to the exclusion of section 4556 for which Employer was cited.

The Board has previously held that it is incumbent upon the Division to cite the safety order that most closely addresses the alleged violative condition, practice, means, method, operation or process that led to the issuance of the citation. (*Truecast Concrete Products,* Cal-OSHA App. 80-394, Decision After Reconsideration (Nov. 21, 1984).) This rule does not, however, preclude the Division from issuing citations for violations of other applicable safety orders under appropriate circumstances.

The ALJ found that the hazard De Leon was exposed to, and which ultimately resulted in his injuries, was attempting to clear an ice jam while the machine was still running. The ALJ noted that the failure to de-energize the ice-crushing machine before attempting to clear the jam, or alternatively, the failure to use proper tools to clear the ice jam, was the actual violative condition. The requirement of de-energizing equipment to avoid inadvertent movement while the machine is adjusted or cleared falls under section 3314(a), which provides:

> Machinery or equipment capable of movement shall be stopped and the power source de-energized or disengaged, and, if necessary, the moveable parts shall be mechanically blocked or locked out to prevent inadvertent movement during cleaning, servicing or adjusting operations unless the machinery or equipment must be capable of movement during this period in order to perform the specific task. If so, the employer shall minimize the hazard of movement by providing and requiring the use of extension tools (e.g., extended swabs, brushes, scrapers) or other methods or means to protect employees from injury due to such movement. Employees shall be made familiar with the safe use and maintenance of such tools by thorough training. For the purpose of Section 3314, cleaning, repairing, servicing and adjusting activities shall include *unjamming* prime movers, machinery and equipment. (Emphasis added)

By its terms, section 3314(a) is intended to protect employees performing the covered activities from inadvertent movement of prime movers, machinery and equipment. Based upon the "unjamming" activity performed by De Leon at the time of his injury, the ALJ concluded that section 3314(a) would have been the proper safety order to have charged Employer. The Board agrees with the ALJ to the extent that section 3314(a) is applicable and could have been cited by the Division; however, finds that its applicability did not preclude the Division from issuing a citation for violation of another safety order, i.e., section 4556, under the facts of this case.

The safety order Employer was cited for violating---section 4556, is a point of operation safety order which is contained in Group 8 - Points of Operation and Other Hazardous Parts of Machinery. Section 4184(a) provides:

> Machines as specifically covered hereafter in Group 8, having a grinding, shearing, punching, pressing, squeezing, drawing, cutting, rolling, mixing or similar action, in which an employee comes within the danger zone shall be guarded at the point of operation in one or a combination of the ways specified in the following orders, or by other means or methods which will provide equivalent protection for the employee.

Within Group 8, section 4556 is contained in Article 69 – Food and Tobacco Machinery which covers ice breaker or crusher and states:

> A hopper shall be provided of such size and arrangement that the hand of the operator cannot come into contact with the revolving teeth or prongs while the machine is in operation. If the top of the hopper is less than 42 inches above the floor or working level, a standard railing shall be provided to prevent an employee from stepping or falling into the hopper.

In this case, De Leon was feeding large vertical-shaped ice blocks[5] into the ice crushing machine prior to and at the time of his injury. His attempt to unjam the ice block utilized a procedure which not only was violative of section 3314(a) as discussed above, but also involved the *continued operation* of the machine.

Both De Leon and Pili testified similarly that it was a regular practice to first attempt to clear ice blocks jammed in the machine by using other ice blocks which are subsequently pushed onto and down the ramp toward the entrance to the machine in order to dislodge the jammed ice block. However, their testimony conflicted when describing the next step taken if the jam was not corrected as described.

De Leon testified that when subsequent feeding of additional ice blocks failed to clear the jam, he would walk down from his regular location in the truck bed to the end of the ramp at the entrance of the ice crushing machine. Using ice tongs, he would reach into the area above the rotating drum and grab the top portion of the jammed ice block and move it back and forth which would usually be enough force to dislodge the ice block that would then drop into the rotating drum which had large spikes on its surface that ground the

[5] According to co-owner Pili, the size of each ice block was approximately 11"x22"X44 inches high although sometimes they could be over four feet but less than five feet in height. Each block weighs approximately 300 pounds.

ice. De Leon stated that the machine was never turned off when jammed and that Pili had previously observed him using the ice tongs without any comment. De Leon stated that he saw how other workers unjammed ice blocks and that the procedure he used was the regular practice.

Pili testified for Employer that there was no reason for an employee to walk down the ramp toward the ice crusher machine during its operation. In the event of an ice block jam which could not be cleared by feeding other ice blocks, he instructed workers to turn off the machine and use an ice shaver (a shovel-like tool with teeth) to chop the ice block into smaller pieces, then re-energize the machine.

In addition to the conflicting testimony regarding the actual procedure for unjamming an ice block, De Leon also described the location of the portable on/off electrical switch which was connected to a cord that was looped around and hung from an upright metal bar at the front of the ice crusher machine. The on-off switch could not be reached from the ground level and required an employee to access it using the feed ramp which leads to the entrance of the machine.[6] De Leon testified that the portable switch was always located in the same area at the front of the machine when the machine operated. On the other hand, Pili indicated that the portable electrical switch is connected to a long cord which is to be extended to the truck bed where the operator could easily access it (without using the ramp or approaching the entrance to the machine).

We find that De Leon's testimony is more credible and reflective of the actual practice for both clearing jams and locating the on-off switch at the entrance of the ice crushing machine. Pili's testimony was often given in terms of the "instructions" or "directions" he gave to employees, including De Leon, for clearing jams on the machine, which fell short of establishing the actual practice used by Employer's employees. Pili's testimony failed to sufficiently rebut De Leon's specific testimony which described a specific practice used by De Leon and other employees.[7]

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[6] De Leon explained that the location of the on-off switch was approximately one foot lower than depicted in Exhibit 10 which is a photograph of the machine which was moved and set up at a different location for purposes of inspection on the day following the accident.

[7] The Board has long-held that an employer's instructions or admonitions are an insufficient means of complying with positive guarding requirements and an inadequate substitute for required guarding. (*Kaiser Aluminum and Chemical Corp.*, Cal/OSHA App. 80-1014, Decision After Reconsideration (Feb. 19, 1985). Health and safety law is premised upon both sufficient instructions provided to workers by Employers as well as ensuring actual performance of safe and healthful practices in accordance with governing safety orders. Establishing that appropriate instruction regarding a procedure was given without addressing evidence establishing a practice consistent with such instruction would impermissibly allow an employer to avoid liability simply by instructing safety one way but permitting a practice another way.

Further, Pili's testimony regarding a reprimand given to De Leon shortly before the accident for using his foot to unjam an ice block only addressed the use of his foot to free an ice jam. Pili's testimony regarding the reprimand did *not* include giving any reprimand for De Leon working *at the entrance to the machine* which was still operating to unjam the ice block—only that he used his foot to clear the jammed ice block. De Leon's testimony that Pili had observed him several times using the tongs to dislodge jammed ice at the entrance to the machine when the machine was located near the office was unrebutted. Thus, Employer did not establish that the incident regarding the reprimand included disapproval of De Leon unjamming the ice block from the location at the machine's feed area or disapproval of De Leon's accessing the jam using the ramp which led to the machine.[8]

In view of our finding that De Leon's testimony establishes the actual practice used by De Leon and other employees to clear jammed ice blocks in the ice crusher machine, the evidence supports the applicability of section 4556 in this case. As a point of operation safety order, section 4556 applies since the machine remained in operation during De Leon's attempt to unclear a jammed ice block and such procedure was dependent upon the spiked drum continuing to rotate and ice continuing to be fed into the machine.[9] Thus, the hazard of falling at the point of operation addressed in section 4556 existed while attempting to clear ice blocks using ice tongs from the location of the ramp edge near the machine's entrance rendering the safety order applicable.

The ALJ also found that, absent an ice jam, the operator would have no reason to walk on the ramp and come within the zone of danger since the chute (ramp) was not a "working level" as characterized by the Division. However, in view of our finding above regarding the practice allowing use of the ramp to clear jams as well as to turn the machine on and off, we find that employees used the ramp sufficiently in the course of their work to establish it as a working level. Section 3207 defines "working level" as follows:

> A platform, walkway, runway, floor or similar area fixed with reference to the hazard and used by employees in the course of their employment. This does not include ladders or portable or temporary means used for access, repair or maintenance, provided

[8] De Leon's description that he was working to clear an ice jam at the time of his fall and the fact that ice tongs were found in the drum after the accident as depicted in Exhibit 7 is consistent with his described practice of using ice tongs to clear the jam from a position at the edge of the ramp at the entrance to the machine.

[9] We also find that the location of the portable electrical on-off switch placed at the entrance of the machine which could only be accessed using the elevated ramp also exposed De Leon to the hazard of falling from the ramp edge into the moving drum area of the machine. In order to turn the machine on and off, he was exposed (albeit momentarily) to the hazard of falling into the machine which had a moving drum with spikes only a few inches below the ramp edge on which De Leon would stand in order to access the on-off switch.

such means are removed immediately upon completion of the work.

De Leon and Pili indicated that the ramp was fixed to the entrance of the machine with a hinge and Pili conceded that it was raised and fastened to the machine only when the machine was moved and stored (not in use). It was undisputed that when used by employees to feed ice into the machine, the ramp was approximately level with the truck bed where the employee would normally feed ice onto the ramp and shove the blocks into the machine. Based upon this configuration and our findings regarding the actual practice and use of the ramp by employees, we find that the ramp was used by employees in the course of employment when clearing jams while the machine continued to operate and when turning the machine on and off. Thus, we find that the ramp was a "working level" within the meaning of sections 4556 and 3207.

There is no dispute that the machine was not guarded in accordance with section 4556. Since an employee was exposed to the hazard of falling into the ice crushing machine from the working level where he was performing his work to clear a jam while the ice crusher machine was operating, Employer violated section 4556 for its failure to guard as required by the safety order.[10]

b. The Evidence Establishes That the Violation Is Serious.

A violation is serious if it is substantially probable that it could result in death or serious physical harm[11] unless the cited employer proves that it did not know of the violation and could not have known of it by exercising reasonable diligence. (Labor Code §§ 6432(a) and (b)) The type of violation which can be classified as "serious" includes "[t]he existence of one or more practices, means, methods, operations, or processes which have been adopted

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[10] The ALJ's decision notes that the Division's inspector conceded that a horizontal bar across the entrance to the drum area would have to be at least four feet high in order to accommodate the ice blocks which were that height, and further, that such a horizontal bar would not be required under section 4556. The Division's witness opined that railings along the sides of the elevated ramp near the entrance to the drum area together with a horizontal bar across the entrance at least four feet above the ramp edge would satisfy the guarding requirement in section 4556. We have previously held that the Appeals Board is not bound by an interpretation or position regarding application of a safety order made by the Division. (*Bostrom-Bergen Metal Products*, Cal/OSHA App. 00-1012, Decision After Reconsideration (Jan. 10, 2003); *Lockheed Missles & Space Co.*, Cal/OSHA App. 79-492, Decision After Reconsideration (Apr. 14, 1982)). We note that the requirements of section 4556 are plainly stated and that the safety order applies to all ice crusher or breaker machines. If a particular machine cannot comply with the requirements of section 4556 or "...by other means or methods which will provide equivalent protection to employees" (§ 4184(a)), such matter is to be addressed either under the variance process available to Employer (Labor Code § 143) or the rulemaking process (Labor Code § 142.2, 142.3)—both of which are under the authority of the Standards Board.

[11] In pertinent part, "serious physical harm" has been equated with "serious injury or illness". (*Abatti Farms/Produce*, Cal/OSHA App. 81-256, Decision After Reconsideration (Oct. 4, 1985), p. 6.)

or are in use, in the place of employment" that could result in death or great bodily harm. (Labor Code section 6432(a)(2))

The Division's inspector, Goossen, testified that he did not observe the operation of Employer's ice crushing machine but has observed other similar machines in operation and that the spikes rotate very fast during the crushing operation. He classified the violation as serious because contact with the spikes on the rotating drum would most likely result in an amputation injury and possible death. According to Goossen, De Leon was fortunate that the tongs fell into the drum and stopped the rotating action before he suffered further injury. De Leon testified that he spent 21 days in the hospital as a result of the injuries to his ankle and foot which included a torn tendon in a toe.

As shown in several photographs introduced into evidence (e.g., Exhibits 6 through 10) showing the machine from different angles, the entrance to the drum area is at the edge of the steel ramp where ice blocks travel into the machine. Employees using tongs to grab the top portion of a jammed ice block in order to dislodge it necessarily stand at the edge of the ramp which is the entrance to the drum area which continues to rotate. In this accident, De Leon had to move a second ice block back to the truck bed which was unsuccessfully used to force free the jammed block. On his way back to the entrance of the machine, he slipped on the wet steel ramp and fell into the machine. He suffered the same type of injury which an operator would incur if he or she fell into the machine making contact with a spiked, fast moving drum.[12] Employer presented no rebuttal evidence to prove that De Leon's injuries were unusually severe or appreciably different than the harm an energized ice crushing machine will inflict on any body part that contacts the spiked, rotating drum. From these facts, the substantial probability that this specific hazard could result in serious physical harm is established.

Employer has the burden of showing that "it did not, and could not, with the exercise of reasonable diligence know of the presence of the violation." (Labor Code section 6432(b)) To prove that Employer could not have known of the violative condition by exercising reasonable diligence, Employer must establish that the violation occurred at a time and under the circumstances which could not provide Employer with a reasonable opportunity to have detected it. (*Sunrise Window Cleaners*, Cal/OSHA App. 00-3220, Decision After Reconsideration (Jan. 23, 2003).)

There is insufficient evidence to establish that the practice of employees to clear jams at the entrance to the machine while it continued to operate

[12] There is also a substantial probability that the same type of injury would occur if an operator slipped or fell at the entrance while turning the machine on or off with the electric switch hanging at the entrance of the machine.

occurred at a time and under circumstances that could not provide Employer with reasonable opportunity to have detected it. On the contrary, De Leon testified that ice blocks jam in the machines with some regularity, and especially the machine he worked on the day of the accident which had a crooked drum, and the procedure he used was also used by other workers as a regular practice. As we previously noted, De Leon was reprimanded for using his foot to free a jammed ice block which Pili observed from his office and we credited Le Leon's testimony regarding the practice used by employees to clear jams in the machine which depended upon the machine's continuing operation. Under these facts, we find that Employer knew or could have known in the exercise of reasonable diligence, of the violative condition for employees clearing jams who are exposed to a hazard of falling into the machine and contacting the spiked, rotating drum.[13]

Since the failure to provide the required guarding to prevent an employee from falling into an ice crushing machine where the hopper was less than 42 inches above the working level of the operator exposed De Leon and other employees using the established practice to clear jammed ice blocks, and Employer knew or should have known of the violative condition, the violation was properly classified as serious.

c. The Division Failed to Prove that the Violation Was Accident Related

A violation may be characterized as "accident related" within the meaning of section 336(c)(3) if the evidence establishes that the violation caused a serious injury, illness, or exposure. (*K.V. Mart Company*, Cal/OSHA App. 01-638, Decision After Reconsideration (Nov. 1, 2002).) To establish the characterization of the violation as "accident related," the Division must show by a preponderance of the evidence a causal nexus between the violation and the serious injury. (*Obayashi Corporation*, Cal/OSHA App. 98-3674, Decision After Reconsideration (June 5, 2001).), i.e., the evidence must establish that Employer's failure to guard in accordance with the cited safety order caused De Leon's serious injury.

The relevant part of section 4556 provides that "a standard railing shall be provided to prevent an employee from stepping or falling into the hopper." Standard railing consists of a top rail, midrail or equivalent protection, and posts and shall have a vertical height within the range of 42 to 45 inches from

[13] We have also held that an employer may be imputed with the requisite knowledge of a serious violation where the hazardous conditions are in plain view since the employer could have known of the condition with the exercise of reasonable diligence. (*Fibreboard Box & Millwork Corp.*, Cal/OSHA App. 90-492, Decision After Reconsideration (June 21, 1991).) Here, the ice crushing machine and its unguarded point of operation hazard as well as the practice of clearing jams with the machine in operation were in plain view and Employer did not contend otherwise.

the upper surface of the top rail to the floor, platform, runway, or ramp level. (section 3209) The midrail shall be approximately halfway between the top rail and the floor, platform, runway, or ramp (*Id.*)

We find that the Division, having the burden of establishing the required causal nexus for purposes of section 336(c)(3), failed to present sufficient evidence to establish that the standard railing required under section 4556 would have prevented De Leon's injury. According to De Leon, upon slipping on a piece of ice on the ramp, he fell and his leg was "sucked into" the machine. De Leon's summary description of his slip near the edge of the ramp and that his leg was "sucked into the machine" does *not* sufficiently establish that his contact at the machine's point of operation would have been prevented by the standard railing described above. If he fell forward upon slipping, the top rail may have prevented a fall. However, if he fell downward as opposed to forward, his leg may have actually slipped under any midrail (required to be half the height of the top rail, i.e., 21-22½ inches) and contacted the drum which then may have sucked his leg into the machine.[14] The little evidence regarding the manner in which De Leon fell is inadequate to allow us to conclude that the violation was accident related under the facts of this case.

Goossen calculated the proposed civil penalty to be $12,600 for a serious violation that caused a serious injury taking into account a 30% credit for size based upon 11 employees. Since we find that the violation of section 4556 was not the cause of the serious injury, we look to the evidence regarding the adjustment and rating criteria used by the Division. In this case, the Division only addressed the size of employer. [15]

We recently held that it is appropriate that an employer be given the maximum credits and adjustments provided under the penalty setting regulations for which no evidence is presented. (*RII Plastering, Inc.*. Cal/OSHA App. 00-4250, Decision After Reconsideration, Oct. 21, 2003).

The initial base penalty for a serious violation is $18,000. (§ 336(c)) The lowest penalty amount provided for by the Director's regulations regarding extent and likelihood allows for a 25% reduction of the base penalty for extent and 25% reduction for likelihood, leaving a gravity based penalty of $9,000.

The Division assigned an adjustment factor of 30% for size based upon 11 employees. However, Pili testified that there were nine employees plus two owners--he and another who is located out of the area. Pili admitted he works

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[14] This latter view is more consistent with the fact that De Leon was able to reach up and turn off the machine using the portable switch hanging from the top of the side wall and above the entrance of the machine.

[15] Where a serious violation causes a serious accident, no penalty reductions are allowable except for size of the employer. (§ 336(d)(1) & (7)).

at the site and draws a salary as an employee, however, there was insufficient evidence to establish whether the absent owner was an employee; thus, we find that there is no support for finding 11 employees which was used to establish the 30% credit for size. Thus, a 40% credit for size which is authorized for 10 or fewer employees (section 336(d)(1) is appropriate. The other adjustment factors for which no evidence was presented provide for maximum credits as follows: good faith--30% (§ 336(d)(2)), and history--10%, leaving a total adjustment factor of 80%. The total adjustment factor of 80% is applied to the $9,000 gravity based penalty resulting in an adjusted penalty of $1,800.

Under section 336(e), Employer is entitled to an additional abatement credit of 50% unless the listed exceptions in the regulation are established. Since the Division did not establish any of the exceptions listed in section 336(e) or otherwise establish the applicability of section 336(f), a 50% credit is allowed, for a total penalty of $900 which we deem appropriate in this case.

DECISION AFTER RECONSIDERATION

The Board reverses the ALJ Decision and determines that the Division established a serious violation of section 4556 and assesses a civil penalty of $900.

MARCY V. SAUNDERS, Member
GERALD PAYTON O'HARA, Member

OCCUPATIONAL SAFETY AND HEALTH APPEALS BOARD
FILED ON: December 4, 2003